MEDICARE and MEDICAID

Brief summaries of
TITLE XVIII and TITLE XIX
of the Social Security Act

May, 1992

NOTE: These summaries are very brief, simple versions of complex subjects. They should be used only as general overviews and guides to the Medicare and Medicaid Programs.

A BRIEF SUMMARY OF MEDICARE

OVERVIEW

Title XVIII of the Social Security Act, entitled "Health Insurance for the Aged and Disabled," is commonly known as "Medicare." The Medicare legislation (part of the Social Security Amendments of 1965) established a health insurance program to complement the retirement, survivors and disability insurance benefits under other titles of the Social Security Act.

When first implemented in 1966, Medicare covered most persons age 65 and over. Since then, legislation has added other groups: (1) persons entitled to disability benefits for 24 months or more (1973); (2) persons with end stage renal disease (ESRD) requiring dialysis or kidney transplant (1973); and (3) certain otherwise non-covered persons who elect to buy into the programs (1973).

When Medicare began on July 1, 1966, there were 19.1 million persons enrolled in the Medicare programs. By December 31, 1966, 3.7 million beneficiaries had received services. On July 1, 1990, over 34 million persons were enrolled in one or both parts of the Medicare program. During calendar year (CY) 1990, 26.6 million beneficiaries used Medicare reimbursed services. The Medicare programs' total reimbursements (including administrative costs) for CY 1990 were $111 billion.

Medicare consists of two parts: hospital insurance (HI), also known as Part A; and supplementary medical insurance (SMI), also known as Part B. During CY 1990, 6.7 million received Part A reimbursed services (for an average per-beneficiary program expenditure of about $8,700 for HI services), and about 26 million received Part B reimbursed services (for an average per-beneficiary program expenditure of about $1,400 for SMI services).

ADMINISTRATION OF MEDICARE

The overall responsibility for administration of the Medicare program lies with the Department of Health and Human Services (DHHS) and the various components: the Health Care Financing Administration (HCFA), the Public Health Service (PHS), and the Social Security Administration (SSA).

HCFA has primary responsibility for Medicare, including: policy and guidelines formulation; contract oversight and operation; maintenance and review of utilization records; and general financing of the program. PHS is responsible for administering the professional health aspects of the Medicare program. SSA is responsible for the initial determination of an individual's entitlement and has overall responsibility for maintaining the

master beneficiary record. The Department of Treasury manages both HI and SMI trust funds, and the transfer of funds to pay the Medicare bills. The trust funds are held by a Board of Trustees, composed of three ex-officio members and two appointed members, which reports the status and operation of the trust funds to Congress on April first of each year.

State agencies (usually State Health Departments under agreements with HCFA) assist by helping DHHS to identify, survey, and inspect provider and supplier facilities or institutions wishing to participate in the Medicare program. In consultation with HCFA, they then certify those that are qualified. The State agency also assists providers as a consultant, and coordinates the various State programs to assure effective and economical endeavors.

MEDICARE COVERAGE

Hospital Insurance (Part A) is generally provided automatically for persons age 65 and over and to most persons who are disabled for 24 months or more who are entitled to Social Security or Railroad Retirement benefits. HI reimburses participating institutional providers for the inpatient hospital, skilled nursing facility, home health, and hospice services that are rendered to beneficiaries who are enrolled in Part A of Medicare.

A major aspect of Part A is the "benefit period," defined as the measurement of time-duration for inpatient care, starting when the beneficiary first enters a hospital, and ending when there has been a break of at least 60 consecutive days since inpatient hospital or skilled nursing care was provided. There is no limit to the number of benefit periods covered by Part A during a beneficiary's lifetime. If a beneficiary exhausts the 90 days of inpatient hospital care available in a benefit period, he or she can use days from a non-renewable "lifetime reserve" of up to 60 additional days of care. In addition to the limits on number of days covered for inpatient hospital care and skilled nursing facility care, HI has co-payment requirements (explained later).

- Inpatient hospital care coverage includes semi-private room, meals, regular nursing services, operating and recovery room costs, intensive care, drugs, laboratory tests, X-rays, and all other medically necessary services and supplies.

- Skilled nursing facility (SNF) care is covered by Medicare HI only if it follows within 30 days (usually) a hospitalization of 3 or more days, and is certified as medically necessary. Covered services are similar to inpatient hospital, plus rehabilitation services and appliances. The number of SNF days provided under Medicare is limited to 100 per benefit period, with a co-payment required for days 21 through 100. Medicare Part A does not cover nursing facility care at all if the patient does not require skilled nursing, or other skilled rehabilitation services which must be given on an inpatient basis.

o **Home health agency (HHA)** care, including a homemaker aide, may be furnished by a home health agency in a home-bound beneficiary's residence if intermittent or part-time skilled nursing, physical therapy or rehabilitation care is necessary. There must be a plan of treatment and periodical review by a physician. Home health care under Part A has no time limitations, no co-payment, and no deductible. However, full-time nursing care, food, blood, and drugs are not provided as HHA services.

o **Hospice** care, added in 1983, is a service provided to those terminally ill persons with a life expectancy of six months or less who elect to forgo traditional medical treatment for the terminal illness, and to receive only limited (hospice) care. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services and symptom management for a terminal illness. However, if a hospice patient requires treatment for a condition not related to the terminal illness, Medicare will pay for all necessary covered services. For the hospice program, the Medicare beneficiary pays a very small coinsurance amount for drugs and the cost of respite care, but pays no deductibles. However, there is a "cap" on per-person hospice expenditures.

Supplementary Medical Insurance (Part B) benefits are available: to almost all resident citizens age 65 and over; to certain aliens age 65 or over - even to those who are not entitled (based on eligibility for Social Security or Railroad Retirement benefits) to Medicare's Part A services; and to disabled beneficiaries who are entitled to Medicare's Part A. Almost all persons entitled to Part A also choose to enroll in Part B.

Part B coverage is optional, and must be paid for through a monthly premium. SMI covers expenditures for institutional services in hospital outpatient departments and ambulatory surgical centers, plus certain non-facility services, including: physician care (in both hospital and non-hospital settings), clinical laboratory tests, durable medical equipment, drugs which cannot be self-administered, diagnostic tests, some other therapy services, most supplies, ambulance, certain other health care services and blood not supplied under Part A. All services must be medically necessary to be covered.

Certain medical services and related care are subject to special payment rules including deductibles (blood), maximum approved amounts (independently practicing, Medicare-approved physical or occupational therapist), or higher cost sharing requirements (outpatient treatment of a mental illness).

Non-Covered services under Medicare include other health care needs (such as eyeglasses, hearing aids, prescription drugs, dentures and dental care, etc.) and long-term nursing care or custodial care. These are not a part of either the HI or the SMI program (unless as a part of a special "coordinated care plan" discussed later).

MEDICARE CLAIMS PROCESSING

Medicare "contractors" are public or private agencies or organizations that contract with HCFA to serve as the fiscal agent between government and providers to locally administer Part A and Part B.

Medicare "intermediaries" process Part A claims for institutional services, including inpatient hospital claims, skilled nursing facilities, home health agencies, and hospice services. They also process Part B outpatient claims. Examples of intermediaries are the Blue Cross and Blue Shield Association (which utilize Blue Cross plans in various States), or commercial insurance companies. Intermediaries' responsibilities include:

- determining costs and reimbursement amounts,
- maintaining records,
- establishing controls,
- safeguarding against fraud and abuse or excess use,
- conducting reviews and audits,
- making the payments to providers for services, and
- assisting both providers and beneficiaries as needed.

Medicare "carriers" handle Part B claims for services by physicians and medical suppliers. Some examples of carriers are the Blue Shield plan in a State or commercial insurance companies. Carriers' responsibilities include:

- determining charges allowed by Medicare,
- maintaining quality of performance records,
- assisting in fraud and abuse investigations,
- assisting both suppliers and beneficiaries as needed, and
- making the payments to physicians and suppliers for services which are covered under Part B.

"Peer Review Organizations" (PROs) are groups of practicing health care professionals who are paid by the federal government to review the care provided to Medicare beneficiaries in each State. PROs act to promote effective, efficient and economical delivery of health care services to the Medicare population they serve. The Peer Review Organizations' responsibilities include:

- deciding if care provided is reasonable, and necessary,
- deciding if care is provided in an appropriate setting,
- reviewing the validity of hospitals' diagnostic information,
- reviewing the appropriateness of admissions and discharges,
- deciding if standards of quality are being met, and
- reviewing the appropriateness of care for which additional payment is sought for extraordinarily costly cases.

MEDICARE FINANCING AND PAYMENTS

Medicare's expenses for both benefits and administration are paid from two separate trust funds. HI's funds accrue mainly from a tax

on individuals' employment earnings. SMI's funds come from payment of premiums by or on behalf of individuals, plus matching general revenue contributions from the Federal Government. In addition, most Medicare covered services require at least some form of beneficiary cost-sharing.

Financing:

For Part A, financing is through mandatory payroll deductions ("FICA tax") from employees and employers, as well as self-employed persons who pay into the HI trust fund. This hospital insurance trust fund is separate from Social Security's Old Age and Survivors' Insurance and Disability Insurance trust funds and from the SMI trust fund. It is used only for HI expenses.

Prior to 1983, payment was made based on a "reasonable cost" basis. Medicare payments for most inpatient hospital care are now, since 1983, under a plan known as the Prospective Payment System (PPS). Under the PPS, a hospital is paid a predetermined amount, based upon the diagnosis within a "diagnosis related group," (DRG) for providing whatever medical care is required during that person's inpatient hospital stay. In some cases the payment is less than the hospital's costs; in other cases it is more. The hospital absorbs the loss or makes a profit. Certain payment adjustments exist for extraordinarily costly cases. Payments for home health, hospice and skilled nursing care coverage continue to be paid under the reasonable cost methodology, with each service having some restrictions and limitations.

For Part B, financing is through premium payments ($31.80 per month in 1992) which are usually deducted from monthly Social Security benefit checks of those who are voluntarily enrolled in the SMI plan, and through significant matching contributions (a total of 72% in 1990) from the general revenue of the federal government.

Physicians are paid on the basis of "reasonable charge". This was defined as the lowest of (1) the physicians's actual charge, (2) the physicians's customary charge, or (3) the prevailing charge in the locality for similar services. Beginning January 1992, the reasonable charges are defined as the lessor of the submitted charges, or a fee schedule based on a relative value scale (called RVS). Durable medical equipment and clinical laboratory services are also based on a fee schedule. Outpatient services and HHAs are reimbursed on a reasonable cost basis.

Beneficiary Payment Liabilities:

For Parts A and B, beneficiaries are responsible for charges not covered by the Medicare program, and for various cost sharing aspects of both HI and SMI. These liabilities may be paid by (1) the Medicare beneficiary, (2) by some other third party such as Medicaid, or (3) by some additional private insurance purchased by the Medicare beneficiary ("Medigap" insurance). The term medigap is used to mean private insurance which, within limits, pays most

of the health care service charges not covered by Part A or B of Medicare. Blue Cross (for Part A) and Blue Shield (for Part B), and many commercial health insurance companies offer such policies, which must meet certain standards imposed by law.

For Part A, the beneficiary's payment share includes a one-time deductible amount at the beginning of each benefit period ($652 in 1992). This covers the beneficiary's part of the first 60 days of each spell of inpatient hospital care. If continued inpatient care is needed, additional coinsurance payments ($163 per day in 1992) are required through the 90th day of a benefit period. Medicare pays nothing after day 90, unless the beneficiary elects to use "lifetime reserve" days. For these, a per-day co-payment ($326 in 1992) is required from the beneficiary.

For skilled nursing care under Part A, the first 20 days of SNF care are fully covered by Medicare; but for days 21 through 100, co-pay ($81.50 per day in 1992) is required from the beneficiary. After 100 days of SNF care per benefit period, Medicare pays nothing. Home health care has no deductible or coinsurance. In any Part A service, the beneficiary is responsible for non-replacement fees for the first three pints or units of blood per calendar year. The beneficiary has the option of paying the fee or having the blood replaced.

For most people age 65 and over, there are no premiums for the HI portion of Medicare. Eligibility for Part A is generally earned through the work experience of the beneficiary, or of a spouse. However, some persons otherwise unqualified for Medicare may purchase HI coverage through a payment ($192 per month in 1992) if they also buy SMI coverage.

For Part B, the beneficiary's payment share includes: one annual deductible (now $100); the monthly premiums; coinsurance payments for Part B services (usually 20% of allowable charges); a blood deductible; and payment for any services which are not covered by Medicare. These "cost-sharing" contributions are required of the beneficiaries for Part B services.

If a doctor or supplier agrees to accept the approved rate as payment in full ("takes assignment"), then payments provided must be considered as payments in full (after co-payments have been met) for that service. No added payments may be sought from the beneficiary or insurer. If the provider does not take assignment, then the beneficiary will be charged for the excess (which may be paid by the medigap insurance). Limits now exist on the excess which providers can charge. However, since Medicare beneficiaries may select their doctors, beneficiaries have the option to choose those who do agree to take assignment.

For ESRD patients, Medicare Part B assists in paying for kidney dialysis and transplants. The regular Part B cost-sharing payments also apply for ESRD services.

MEDICARE COORDINATED CARE PLANS

Managed care (prepaid health care plans), such as competitive medical plans (CMPs) and health maintenance organizations (HMOs), is an option for Medicare beneficiaries. Coordinated care plans function on a basis different from regular fee-for-service plans. Under managed care plans, Medicare beneficiaries receive their medical services at a comprehensive health care setting within a service area. This public or private organization provides health care services at a predetermined per-person rate, regardless of frequency or extent of utilization by its enrollees.

Coordination of all health care services is central to the HMO and CMP concept. To insure this coordination, all of the beneficiary's health care services, except for emergency care, are obtained from the professionals and facilities affiliated with the HMO or CMP which the beneficiary has selected.

In addition to those services usually provided under Medicare fee-for-service plans, the managed care plans often cover services such as preventive care, eyeglasses, dental care, or hearing aids. The election to participate in a coordinated care plan may also serve as an alternative to purchasing medigap insurance (often wanted if the beneficiary is in a traditional fee-for-service plan). And, although there are certain restrictions and limitations, the coordinated care plan's larger fixed monthly premiums and smaller coinsurance payments provide more predictability for out-of-pocket costs for the beneficiaries who do not have medigap insurance.

MEDICARE - MEDICAID RELATIONSHIP

Medicaid (Title XIX of the Social Security Act) is a joint Federal and State cooperative program to provide medical care for qualified very poor persons. Certain Medicare beneficiaries are also involved with Medicaid under two specific conditions:

The Medicaid program - which includes coverage for those Medicare beneficiaries who are poor enough to meet the limited income and assets standards set by each State's Medicaid program. These Medicare/Medicaid beneficiaries are known as "dual eligible" recipients. For these dual eligible persons, State Medicaid programs usually pay the premiums and cost-sharing for Medicare and supplement the Medicare program by providing some additional health care services offered by their State's Medicaid program (e.g., long term nursing home care, eye-glasses, dentures, etc. - as each State elects). Services under the Medicaid State Plans vary from State to State; thus health care services provided under Medicaid for the dual eligible beneficiaries also vary from State to State.

The qualified Medicare beneficiary (QMB) program - which helps Medicare beneficiaries who have very limited assets and income which is below the federal poverty level, but who are not quite poor enough for regular Medicaid eligibility. For these "QMB-only"

beneficiaries, the Medicaid program in each State pays the Medicare premiums and cost-sharing amounts. Although each State can decide (beyond mandated coverage) the extent of coverage for its QMB residents, regular Medicaid coverage usually is not provided to these "QMB-only" persons. They benefit because they do not have personal responsibility for the Medicare premiums and cost-sharing.

SUMMARY

HCFA and Congress continually seek to provide better quality care in a more cost efficient manner to meet the health care needs of our age and disabled citizens. The challenge is enormous, and escalating. Medicare payments for just the Hospital Insurance (Part A) benefits for fiscal year (FY) 1990 were $65.9 billion. Payment for HI benefits are expected to exceed $83.2 billion for FY 1993. For the Supplementary Medical Insurance (Part B), FY 1990 benefit payments were $41.5 billion. Payment for SMI benefits are expected to total almost $60 billion for FY 1993.

On average, about twenty percent of all Medicare beneficiaries use HI services in a year, and over eighty percent of all Medicare beneficiaries use SMI services in a year. When combining all payments for Medicare services received in 1990 for all types of Medicare beneficiaries who received any Medicare service, the average program expenditures per person for FY 1990 was $4,094.

If expenditures continue at the current rate, with no significant changes to the health care programs, then the total trust funds disbursements for Medicare are estimated to be $180 billion by FY 1995. By FY 2000, these expenditures for the Medicare program may well exceed $310 billion.

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A BRIEF SUMMARY OF MEDICAID

Overview

Title XIX of the Social Security Act is a matching entitlement program which provides medical assistance for certain individuals and families with low incomes and resources. The program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the Federal and State governments to assist States in the provision of more adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America's poorest people.

Within broad national guidelines which the Federal government provides, each of the States: (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Thus, the Medicaid program varies considerably from State to State, as well as within each State over time.

In 1990, the Medicaid program provided medical services to over 25 million eligible poor persons who were aged, blind, disabled, pregnant, or in certain families with children. Federal and State combined payments to medical vendors for Medicaid services were reported by the States as being $64.86 billion for 1990, while total expenditures for the Medicaid program were $68.7 billion ($38.9 billion Federal and $29.8 billion State monies), plus administrative costs.

Maintenance Assistance Status and Basis of Eligibility

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, States are required to provide Medicaid coverage for most individuals who receive Federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. These are the mandatory Medicaid eligibility groups:

- Recipients of Aid to Families with Dependent Children (AFDC);
- Supplemental Security Income (SSI) recipients (or aged, blind and disabled individuals in States that apply more restrictive eligibility requirements);
- Infants born to a Medicaid-eligible pregnant woman. Medicaid eligibility must continue throughout the first year of life so long as the infant remains in the woman's household and she remains eligible, or would be eligible if she were still pregnant;
- Children under age 6 and pregnant women who meet the State's AFDC financial requirements or whose family income is at or below 133 percent of the Federal poverty level. States are required to extend Medicaid eligibility until age 19 to all children born after September 30, 1983 in families with incomes at or below the Federal poverty level. This phases in coverage, so that by the year 2002, all poor children under age 19 will be covered;

- Recipients of adoption assistance & foster care under Title IV-E of the Social Security Act;

- Certain Medicare beneficiaries (described later); and

- Special protected groups (These are usually individuals who lose cash assistance because of the cash program's rules, but who may keep Medicaid for a period of time. Examples are persons who lose AFDC or SSI payments due to earnings from work or increased Social Security benefits. Two-parent, unemployed families whose cash AFDC assistance is limited by the State are protected and are provided a full 12 months of Medicaid coverage).

States also have the option to provide Medicaid coverage for other "categorically needy" groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. The broadest optional groups that States may cover (and for which they will receive Federal matching funds) under the Medicaid program include:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is below 185% of the Federal poverty level (the percentage to be set by each State);

- Certain aged, blind or disabled adults who have incomes above those requiring mandatory coverage, but below the Federal poverty level;

- Children under age 21 who meet income and resources requirements for AFDC, but who otherwise are not eligible for AFDC;

- Institutionalized individuals with income and resources below specified limits;

- Persons receiving care under home and community-based waivers;

- Recipients of State supplementary payments; and

- "Medically needy" persons (described below).

The option to have a "medically needy" program allows States to extend Medicaid eligibility to additional qualified persons who have too much income to qualify under the mandatory or optional categorically needy levels. This option allows them to "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income, thereby reducing it to a level below the maximum allowed by that State's Medicaid plan. States may also allow families to establish eligibility for medically needy coverage by paying monthly premiums to the State in an amount equal to the difference between family income (reduced by unpaid expenses, if any, incurred for medical care in previous months) and the threshold allowance for income eligibility.

The "medically needy" Medicaid program does not have to be as extensive as the categorically needy program. However, if a State does elect to have a medically needy program, it is required to provide coverage to certain children under age 18 and pregnant women. It may choose to provide coverage to other medically needy persons: aged, blind, and/or disabled persons; caretaker relatives of

children deprived of parental support and care; and certain other financially eligible children up to age 21. During 1990, thirty eight States provided Medicaid to at least some groups under a medically needy program.

Amplification on Medicaid Eligibility

Once entitlement to Medicaid is determined, coverage generally is retroactive to the third month prior to application. Coverage generally stops at the end of the month in which a person's circumstances change. Most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for the Medicaid program. No Federal funds are provided for State-only programs.

Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the Federal statute (except for emergency services for certain persons) the Medicaid program does not provide health care services, even for very poor persons, unless they are in one of the groups designated above. Low income is only one test for Medicaid eligibility; assets and resources are also tested against established thresholds. As noted earlier, categorically needy persons who are eligible for Medicaid may or may not also receive cash assistance from the AFDC program or from the SSI program, and medically needy persons who would be categorically eligible except for income or assets may become eligible for Medicaid solely because of excessive medical expenses.

Significant changes were made in the Medicare Catastrophic Coverage Act (MCCA) of 1988 which impacted Medicaid. Although much of the MCCA was repealed, the portions impacting Medicaid remain in effect. Recent changes in the law also have accelerated Medicaid eligibility for some nursing home patients by protecting more income and assets for the institutionalized person's spouse at home. Before an institutionalized person's monthly income is used to pay for the cost of institutional care, a minimum monthly maintenance needs allowance is deducted for bringing the income of the community spouse up to a moderate level (within the available income).

For certain poor Medicare recipients known as "qualified Medicare beneficiaries" or "QMBs" (those beneficiaries with incomes below the Federal poverty level and with resources at or below twice the standard allowed under the SSI program), the Medicaid program in most States pays the Medicare premiums, deductibles and certain coinsurance costs, if the recipient applies for this help. These new QMBs are not quite poor enough to qualify for Medicaid and usually are not eligible for Medicaid services; they benefit because their Medicare cost-sharing expenses are paid by the State Medicaid programs.

Scope of Medicaid Services

Title XIX of the Social Security Act requires that, in order to receive Federal matching funds, certain basic services must be offered in any State program:

- inpatient hospital services;
- outpatient hospital services;
- prenatal care;
- physician services;

- nursing facility (NF) services for individuals aged 21 or older;
- home health care for persons eligible for skilled-nursing services;
- family planning services and supplies;
- rural health clinic services;
- laboratory and x-ray services;
- pediatric and family nurse practitioners service;
- certain Federally-qualified ambulatory and health-center services;
- nurse-midwife services; and
- early and periodic screening, diagnosis, and treatment (EPSDT) services for children under age 21.

States may also receive Federal assistance for funding if they elect to provide other optional services (currently 32 options). The most commonly covered optional services under the Medicaid program include:

- clinic services;
- nursing facility services for the aged and disabled;
- ICF services for the mentally retarded (ICFs/MR);
- optometrist services and eyeglasses;
- prescribed drugs;
- prosthetic devices; and
- dental services.

A new optional service now allows States to provide home and community-based care to certain individuals who are either medically needy or eligible for Medicaid due to receipt of SSI benefits: those who have limitations in specified activities of daily living (toileting, transferring, and eating), and are at least 65 years of age. The services to be provided to these persons may include personal care services, chore services, respite care services, adult day care, homemaker/home health aide, and nursing services. Another option allows up to eight States to elect to establish and provide community-supported living arrangement services for individuals with mental retardation or a related condition.

Amount and Duration of Medicaid Services

Within broad Federal guidelines, States determine the amount and duration of services offered under their Medicaid programs. They may limit, for example, the days of hospital care or the number of physician visits covered. States are prohibited from limiting the duration of coverage for medically necessary inpatient hospital services provided to Medicaid-eligible children under age six in disproportionate share hospitals and to infants in all hospitals.

With certain exceptions, a State's Medicaid plan must allow recipients freedom of choice among participating providers of health care. States may provide and pay for Medicaid services through various pre-payment arrangements, such as a health maintenance organization (HMO). In general, States are required to provide comparable services to all categorically needy eligible persons. There are two important exceptions:

1) Health care services identified under the EPSDT program as being "medically necessary" for eligible children must be provided by Medicaid, even if those services are not included as part of the covered services in that State's plan; and

2) States may request home and community-based services "waivers" under which they offer an alternative health care package for persons who would otherwise be institutionalized under Medicaid. States are not limited in the scope of services they can provide under such waivers so long as they are cost effective (except that, other than as a part of respite care, they may not provide room and board for such recipients).

Medicaid - Medicare Relationship

Some aged and/or disabled person are covered under both Medicaid and Medicare (Title XVIII of the Social Security Act). These recipients are known as "dual beneficiaries" or "dual eligibles". The Medicare program provides Hospital Insurance (HI, also known as Part A) and Supplementary Medical Insurance (SMI, also known as Part B). For those persons aged 65 or older (and for certain disabled persons) who have insured status under Social Security, coverage for HI is automatic.

Coverage for SMI, however, requires payment of a monthly premium. For the dual-eligible persons, the State Medicaid programs pay the premiums, deductibles and certain coinsurance Medicare costs. For the dual-eligible recipients, Medicaid supplements the Medicare coverage, and provides many health care services that are not provided under Medicare. Services such as eyeglasses, hearing aids, and nursing facility care beyond the 100 day limit provided by Medicare may be included, as each State elects.

Disabled persons who lost Medicare benefits because of their return to work are now allowed to purchase Medicare HI and SMI coverage. For those disabled working persons with income below 200 percent of the Federal Poverty level, the State Medicaid programs must pay the HI premium. The State Medicaid programs are not required to pay SMI premiums for these recipients.

Payment for Medicaid Services

Medicaid operates as a vendor payment program, with payments made directly to the providers. Providers participating in Medicaid must accept the Medicaid reimbursement level as payment in full. Each State has broad discretion in determining (within Federally-imposed upper limits and specific restrictions) the reimbursement methodology and resulting rate for services, with two exceptions: 1) for institutional services, payment may not exceed amounts that would be paid under Medicare payment rates; and 2) for hospice care services, they must pay no lower than Medicare rates.

States may impose nominal deductibles, coinsurance or co-payments on some Medicaid recipients for certain services. Emergency services and family planning services must be exempt from such co-payments. Certain Medicaid recipients must be excluded from this cost sharing: pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to institutional care, and categorically needy HMO enrollees.

The amount of total Federal outlays for Medicaid has no set limit (cap); rather, the Federal government must match whatever the individual State decides to

provide, within the law, for its eligible recipients. However, reimbursement rates must be sufficient to enlist enough providers so that Medicaid care and services 2re available under the plan at least to the extent that such care and services are available to the general population in that geographic area. Also, States must augment payment to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid recipients and/or other low-income persons.

The portion of the Medicaid program which is paid by the Federal government, known as the Federal Medical Assistance Percentage (FMAP), is determined annually for each State by a formula that compares the State's average per capita income level with the national average. By law, the FMAP cannot be lower than 50 percent nor greater than 83 percent. The wealthier States have a smaller share of their costs reimbursed. In 1991, the FMAPs varied from 50 percent (paid to 12 States and D.C.) to 79.93 percent (to Mississippi), with the average Federal share among all States being 57 percent for Medicaid service expenditures. The Federal government also shares in the State's expenditures for administration of the Medicaid program. Most administrative costs are matched at 50 percent for all States. However, depending on the complexities and need for incentives for a particular service, higher matching rates (75, 90 and 100 %) are authorized for certain functions and activities.

Medicaid Trends and Statistical Summary

Medicaid was initially formulated as a medical care extension of Federally funded income maintenance programs for the poor, with an emphasis on dependent children and their mothers. Over time, however, Medicaid has been diverging from a firm tie to eligibility for cash programs. Recent legislation assures Medicaid coverage to an expanded number of low-income pregnant women, poor children and some Medicare beneficiaries who are not eligible for any cash assistance program, and who would not have been eligible for Medicaid under the earlier Medicaid rules. Changes also focus on enhanced outreach toward specific pregnant women and children, increased access, continuation of specific benefits, restrictions on service limits, and quality of care.

The percent of total Medicaid funds spent for home health care is now four times as much as ten years ago. Intensive care for very premature babies or others with very serious problems can cost $3,000 per day per baby now. A few other persons who have complex and extensive health care needs on a continuing basis cost the Medicaid program over $200,000 per person per year for many years. The average Medicaid payment for ICF/MR care was over $50,000 per recipient in 1990. By comparison, 1990 Medicaid vendor payments for the total health care services for AFDC children under age 21 averaged only $811 per child.

In addition to the increase in numbers of beneficiaries from new legislation, the most pronounced Medicaid trend in recent years has been the continued sharp increase in expenditures for intensive acute care, for nursing facility care for the mentally retarded and disabled, and for home health and nursing facility services for the aged and disabled. In 1990, the various types of long term care services for the elderly, disabled and mentally retarded required forty-three percent of all Medicaid payments.

The following displays, summarized from data provided annually by the States, show the distributions of the 25 million Medicaid recipients and of the amounts

paid for the almost $65 billion in services they received in 1990. These payments are only for direct provision of health care. They do not include Medicaid payments for the premiums for Medicare, HMOs or others; nor do they include administrative costs.

(I) **Numbers of Medicaid recipients and vendor payments by categories of people:**

Categories of People		Payments
. 11,219,969 were dependent children under age 21	@	$ 9,100,096,000;
. 6,010,407 were AFDC adults or pregnant women	@	$ 8,589,738,000;
. 3,634,678 were permanently & totally disabled	@	$23,969,413,000;
. 3,202,129 were aged 65 or older	@	$21,508,078,000;
. 989,543 were other Title XIX recipients	@	$ 1,050,654,000;
. 83,315 were blind	@	$ 434,233,000.

(II) **Numbers of Medicaid recipients and vendor payments by types of services:**
(Recipients may use multiple services, thus may be counted more than once)

Types of Services		Payments
. 4,685,553 received inpatient hospital services	@	$18,387,780,000;
. 1,461,317 received other nursing facility care	@	$17,693,483,000;
. 146,931 received ICFs/MR services	@	$7,353,596,000;
. 17,294,416 received prescription drug services	@	$4,420,216,000;
. 17,078,446 received physician services	@	$ 4,018,144,000;
. 719,194 received home health services	@	$ 3,403,955,000;
. 12,370,205 received outpatient hosp. services	@	$ 3,324,319,000;
. 5,126,540 received other or unidentified care	@	$ 2,385,665,000;
. 2,803,971 received clinic services	@	$ 1,687,988,000;
. 8,959,413 received lab and x-ray services	@	$ 721,163,000;
. 4,552,049 received dental services	@	$ 497,855,000;
. 3,872,823 received other practitioner services	@	$ 372,423,000;
. 1,751,618 received family planning services	@	$ 264,869,000;
. 2,951,633 received EPSDT services	@	$ 197,919,000;
. 223,613 received rural health clinic care	@	$ 34,410,000.

Federal outlays for the Medicaid program have increased from $2.5 billion in fiscal year (FY) 1970 to $38.9 billion in FY 1990. Under current law, the projected growth of Federal Medicaid expenditures is expected to be 25% just for FY 1991. The compound rate increase between FY 1990 and FY 1995 is now projected to average over 17% per year (or a doubling in about four years). Thus, if the current program and expenditure trends continue and there are no significant changes to the Medicaid program, payments for the total Federal and State Medicaid program for 1995 are projected to be near $180 billion, and may well exceed $300 billion by the year 2000.

Conclusion

Medicaid policies for eligibility and services are complex, and vary considerably even among similar-sized and/or adjacent States. A person who is eligible in one State might not be eligible if in another State. Services provided by one State may differ considerably in amount, duration or scope from services provided in a similar State. Increase in expenditures for the total Medicaid program over the years have exceeded

the increase in numbers of persons or services provided. That is, the cost per Medicaid recipient has increased annually. This seems due, primarily, to:

- the accelerated rate of inflation for medical and health-related services when compared to general inflation;

- the results of technological advances to keep more very low birth-weight babies and other critically ill or severely injured persons alive, but in need of continuing very expensive care;

- the increase in rates of reimbursement to the health care providers;

- the addition of new requirements to the Medicaid program; and

- the increase in the numbers of very old and disabled persons requiring extensive acute and/or long term health care and related services.

The U.S. Congress, the Department of Health and Human Services and the individual States continually seek to make improvements in Medicaid's quality, effectiveness and extent of health care services. But the Medicaid programs must function within the Federal and State constraints of budgetary limitations as well as other economic, social, and political factors. Thus, with frequent revisions in Federal laws, in HCFA regulations, and in individual State plans, the Medicaid program is continually changing. This is a brief summary of the Medicaid program as of May, 1992.

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